

(f) *Special provision.* Any increases in a State's aggregate disproportionate payments, that are made to meet the minimum payment requirements specified in § 447.296(b)(5), may exceed the State base allotment to the extent such increases are made to satisfy the minimum payment requirement. In such cases, HCFA will adjust the State's base allotment in the subsequent Federal fiscal year to include the increased minimum payments.

[57 FR 55143, Nov. 24, 1992, as amended at 58 FR 43182, Aug. 13, 1993]

**§ 447.299 Reporting requirements.**

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to HCFA the quarterly aggregate amount of its disproportionate share hospital payments made to each individual public and private provider or facility. States' reports must present a complete, accurate, and full disclosure of all of their DSH programs and expenditures.

(b) Each State must report the aggregate information specified under paragraph (a) of this section on a quarterly basis in accordance with procedures established by HCFA.

(c) Each State must maintain, in readily reviewable form, supporting documentation that provides a detailed description of each DSH program, the legal basis of each DSH program, and the amount of DSH payments made to each individual public and private provider or facility each quarter. This information must be made available to Federal reviewers upon request.

(d) If a State fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of FFP HCFA estimates is attributable to the expenditures made to the disproportionate share hospitals as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

**Subpart F—Payment Methods for Other Institutional and Non-institutional Services**

SOURCE: 43 FR 45253, Sept. 29, 1978, unless otherwise noted. Redesignated at 46 FR 47973, Sept. 30, 1981. Redesignated at 58 FR 6095, Jan. 26, 1993.

**§ 447.300 Basis and purpose.**

In this subpart, §§ 447.302 through 447.334 and 447.361 implement section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy and quality of care. Section 447.371 implements section 1902(a)(13)(F) of the Act, which requires that the State plan provide for payment for rural health clinic services in accordance with regulations prescribed by the Secretary.

[46 FR 48560, Oct. 1, 1981, as amended at 61 FR 38398, July 24, 1996]

**§ 447.301 Definitions.**

For the purposes of this subpart—

*Brand name* means any registered trade name commonly used to identify a drug.

*Estimated acquisition cost* means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers.

*Multiple source drug* means a drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.

[52 FR 28657, July 31, 1987]

**§ 447.302 State plan requirements.**

A State plan must provide that the requirements of this subpart are met.

[46 FR 48560, Oct. 1, 1981]

**§ 447.304 Adherence to upper limits; FFP.**

(a) The Medicaid agency must not pay more than the upper limits described in this subpart.